

**Idaho Board of Health and Welfare  
Minutes**

**June 14, 2006**

The Board of Health and Welfare convened at:  
Holiday Inn – Madeira Conference Room  
1399 Bench Road  
Pocatello, Idaho

**CALL TO ORDER**

Chairman Kenyon called the meeting to order at 9:00 am.

**ROLL CALL**

Sherri Kovach called the roll.

**Board Members Present:**

Quane Kenyon, Chairman  
Dr. Richard Roberge  
Stephen Weeg  
Dan Fuchs  
Janet Penfold (arrived at 11:15 am)  
Don Gross

**Board Members Absent:**

Janet Penfold (absent until 11:15 am)  
Larry Vincent

**Ex-Officio Members Present:**

Representative Sharon Block

**Ex-Officio Members Excused:**

Senator Dick Compton

**Department of Health and Welfare Staff Present:**

Dick Armstrong, Director  
Dave Butler, Deputy Director  
Dick Schultz, Deputy Director  
Jeanne Goodenough, DAG  
Martha Puett, Director's Office  
Tom Shanahan, Public Information  
Sherri Kovach, Administrative Procedures  
Ken Deibert, FACS  
Randy May, Medicaid

Tracy Farnsworth, SHS  
Patti Campbell, Medicaid  
Nick Arambarri, Reg. Dir.  
Jane Smith, Health

**Others Present:**

Tyler Dahltre, Transitions, Inc.  
Amy Cunningham, Co-Ad, Inc.  
Scott Birkinbine, DDA  
Lisa Cahill, IADDA  
Carl Jones, IADDA

**PUBLIC COMMENT PERIOD**

Chairman Kenyon opened the floor for public comment for 15 minutes on any subject not specifically shown on the agenda. Since no one stepped forward to make any comments, the comment period was closed.

**AGENDA ITEM #1:      INTRODUCTION OF NEW BOARD MEMBER**

Chairman Kenyon welcomed and introduced Don Gross, new Board member representing Region 1. Mr. Gross stated he was very excited to have the opportunity to work on this Board and help direct policies and procedures for future use. He is a care provider and is quite aware of the cost of providing services to citizens of this state, and realizes that if the Department/Board don't work together, both through the private and public sector, the state will soon run out of money.

Chairman Kenyon reported that the other Board member appointed, Larry Vincent, is a long time acquaintance of his and knows him quite well. They worked together when they were involved in the Legislature (the Chairman was a reporter and Mr. Vincent was in the Legislature). From there Mr. Vincent was elected as County Commissioner and was then appointed to the District Health Board for a number of years, so he will bring a wealth of experience. Unfortunately, Mr. Vincent's wife is ill, and he wasn't comfortable in traveling out of town.

**AGENDA ITEM #2:      APPROVAL OF BOARD MINUTES**

Chairman Kenyon presented the minutes of the November 9 & 10, 2005 meeting for adoption.

**Motion:**               Dr. Roberge moved for approval of the minutes of the  
November 9 & 10, 2005 Board Meeting.

**Second:**             Dan Fuchs

**Vote:**                Motion carried. 5 Ayes               0 Nays               2 Absent

**AGENDA ITEM #3:      APPOINTMENT OF NOMINATING COMMITTEE**

Chairman Kenyon appointed a nominating committee of Dan Fuchs and Stephen Weeg; according to HB 832 the Board is to elect new officers, which will be conducted at the July meeting. House Bill 832 does away with the current of position of Board Secretary; the new Board Secretary as of July 1<sup>st</sup> will be the Director of Health and Welfare.

**AGENDA ITEM #4:      DIRECTOR'S REPORT**

Director Armstrong stated that due to the short tenure in office, he would defer to Mr. Butler to provide reports.

Mr. Butler, Deputy Director, reported that along with the reports noted on the agenda, Tracy Farnsworth, Administrator for State Hospital South, will provide a presentation on the Department's customer service initiative. These relate to the Board's new responsibilities, which take effect July 1, 2006. Part of the Board's new responsibilities in House Bill 832, Section 10, Part D, directs the Board to review and advise the Director and the Governor on Department initiatives. To assist in the

Board's new role and as there is a mass of information that will be directed to the Board, Department staff wanted to cover some of these initiatives even though the responsibilities are not in place.

### **Legislative Update**

Mr. Butler reported the Department had a very generous Legislative session. Some of the items requested by the Department did not get in the Governor's recommendation and were prioritized out; however, the Legislature revisited some of those items and gave the Department more funding than what was proposed by the Governor. The Department received a three percent CEC, (change in employee compensation), which helped with the retention and morale of the employees, who hadn't seen a permanent raise in the last few years. The Department also received an expansion of State Hospital North. State Hospital North has fifty beds, and currently runs a census of about 43 to 45 patients. The Governor recommended additional funding for staff to get census up to 48 - 49 beds. Not only did the Legislature support the increased staffing, they also allocated capital funds necessary to expand the hospital from 50 beds to 55. The additional beds will help with the increase of community psychiatric hospitalization. Additionally, the Department had requested one ACT team—a group of clinical social workers or clinicians who work with clients to help make sure that the clients take their medication. By making sure clients take their medication, it reduces the chance of potential expensive hospitalization. The Legislature gave approval for two ACT teams; each team consists of eight individuals.

Mr. Butler reported the Legislature also passed a targeted change in employee compensation, which impacts seven classes of employees within the Department, primarily social workers, nurses and the self reliance specialists. The increase and the target money have also helped with the Department's employee retention issues. Due to the increase and the target money, the Department has seen the turnover rate go from roughly about 8% to roughly 6% in the last month. Hopefully the downward trend in turnover will continue; however, realistically the Department doesn't think it can get much lower due to the normal ebb and flow, (retirements, transfers, increased salary in the private sector, etc.), in an organization of 3,100 employees.

Mr. Butler reported the biggest rule docket, Medicaid Reform, passed through the Legislature with a fair amount of publicity. The Department worked with the Governor and took a one-size-fits-all system and broke it down into three different plans, which mirror the private insurance industry. Mr. Butler stated the Department wished to publicly thank former Governor Kempthorne, and David Lehman, Policy Director, for shepherding the reform. Huge thanks to David Rogers, former Medicaid Division Administrator, as well as Leslie Clement, Kate VandenBroek, and countless other staff who sat through numerous hours of legislative testimony. There was a significant number of staff in the Divisions of Medicaid and Self Reliance who also assisted and deserves much credit and thanks. Representative Sharon Block, Chairman of the House Health and Welfare Committee, deserves many great thanks, as she took it upon herself and worked with the members of her committee to actually hear the testimony, pass it through the committee, and carry it through the floor of the House. Representative Block also worked with members of the Senate Health and Welfare Committee and Senate floor.

### **Medicare Part D**

Randy May, Deputy Administrator, Division of Medicaid, distributed and reviewed information on the Medicare Modernization Act or as it is better known, Medicare Part D. Mr. May reported that prescription drug coverage actually began January 1, 2006 and is available to anybody who is eligible for Medicare Part A or enrolled in Medicare Part D; there are 194,000 eligible Idaho citizens. There was an open enrollment period from January 15 - May of 2006. Within the State there are 23 prescription drug plans with an average monthly premium of \$32.00 per month. There are 12 prescription drug plans, which have nominal \$5.00 co-pay, that are specifically targeted towards low income folks. The biggest impact the Department saw was effective January 1, 2006. That is when all of the dual eligible, people

who enrolled in both Medicare and Medicaid, had their prescription drug benefit coverage shifted out of Medicaid into Medicare, with a minor exception of a small number of people. What this caused the Department to do was to take on some very significant augmentation of its programs. The eligibility system and the AIM processing system needed to be able to identify those people who are eligible for the Medicare program, so that when the pharmacy claim was received, the Department could accurately determine whether that claim should be more appropriately paid by Medicare or whether it was something that's covered by Medicaid. That work was completed in time for the January roll out. Out of the 194,000 Medicare eligible Idahoans, 76% were above the 150% federal poverty level. There are 29,000 Idahoans who fall below the 150% of federal poverty level, some of which are eligible for low income subsidy or eligible for Medicaid benefits. The Department was obviously concerned with the 29,000 who could potentially be eligible under the low income subsidy, and thus be deluged with a significant increase in applications for Medicaid benefits. This, however, this did not come to pass. Out of the 194,000, 9% or 17,000 of the dual eligibles who are receiving Medicaid, Medicare, and obviously the Medicare prescription drug coverage, will also receive the low income subsidy.

The Department took the lead and assembled a Medicaid Modernization Act Partnership Coalition. The central group met in Boise and was chaired by Representative Kathie Garrett. The agencies involved included the Idaho Commission on Aging; the Idaho Department of Insurance, particularly their Senior Health Benefits Insurance Administration; and Department staff from Medicaid, Self Reliance, Family and Community Services, and Regional Directors. Also, there was a partnership with the Social Security Administration, the Center for Medicare and Medicaid Services; and representatives from three of the four congressional offices. Also involved were the statewide associations, i.e., the Idaho Assisted Living Association, the Idaho Pharmacy Association, and a number of professional groups to ensure state-wide coverage. The Coalition worked to be innovative and find people where they lived and/or congregated, i.e., county fairs, health fairs, senior centers, community centers, Meals on Wheels, nursing homes, doctor's offices, etc. The 211 CareLine was used to link clients with health services and enrollment centers in their respective areas. The Department also partnered with pharmacists and other medical providers, and it has to be said that probably the most unselfish persons in this rollout have been the pharmacists. Invariably what happened is, the client, who doesn't understand the bureaucracy, presents at the pharmacy counter to have a prescription filled and doesn't have the money to pay for it. The client knows they are enrolled in a plan and they just can't figure out how to make it work. Mr. Fuchs and many people like him clearly went the extra mile to ensure clients were able to walk away with their prescriptions. Mr. May reported he and other Medicaid staff spent many hours talking with pharmacists trying to figure out how to make the 28 different automated systems talk to each other so each person could walk away from the counter with his medication.

Also, the Department established 130 one-stop enrollment centers, and provided computers, web access, printers, and trained staff, which helped provide information application assistance and actually do prescription drug enrollment from the enrollment centers. Mr. May commented that Medicare's strategy was to base the enrollment process via the Internet, which sounds neat and slick, except that when you look at the elderly population, less than 10% of them are computer literate and regularly go out to surf the web. The Department also provided laptops and trained nurses and pharmacists to go into the home of people who were homebound. The Division of Family and Community Services assisted with complex cases by providing a mental health specialist. There were over 26,000 face-to-face encounters with clients to help them navigate the enrollment process. Impacts to the Department include on-going increased workload to staff. The enrollment program is out there and growing, particularly as we get closer to 2011 when baby boomers approach retirement age. Education, application assistance, preferred drug plan review and case work will continue. The Centers for Medicare and Medicaid Services has stated that somewhere between 25 and 30 percent of the current prescription drug plans will go under in the first two years, which means that all of the people currently signed up will be dropped. The people

who were assigned to that defunct plan will again require assistance to re-navigate, reorient and re-enroll in another plan. The Department has noted that Medicaid prescription drug spending is down about 40%. The Department has projected one million fewer drug claims per year; however as spending decreases, so does the total drug rebate amount. The federal government has a funding mechanism that they have put in place called "Clawback", which negates a percentage of the State's savings.

Mr. May reported that the feedback from the Centers for Medicare and Medicaid Services was that Idaho's implementation was "superb." Medicare liked the fact that the Department was quite proactive as early as March of 2005; most other states started their work right around November. Medicare also thought that the leadership and planning and the Department's network was the best that they had seen anywhere in the country. They were also very impressed with the Department's rapid response and service, to be able to go in and triage those complaints that were happening from folks who were standing at pharmacists' counters. There were literally hundreds of triage calls made to ensure that the clients got their prescriptions. The bottom line is that out of the 194,000 Idahoans who were eligible, numbers indicate that 128,764 were actually enrolled under the prescription drug plan. Board members commented that the Department, along with the other Coalition members, did a great job in pulling off this effort. Kudos to everyone involved with the program, especially the pharmacists who were often left waiting for payments.

### **Integrated Services**

Ken Deibert, Division Administrator, Family and Community Services, distributed and reviewed Policy Memorandum No. 05-12, titled "Criteria for Referral to Navigation Services and Participation With Multidisciplinary Teams." The purpose of the policy is to provide guidance for Department staff regarding those individuals and families who should be encouraged by program staff to seek navigation services or work with a multidisciplinary team. As a public human service agency, the Department is committed to promoting and protecting the health and safety of Idahoans. To help accomplish that mission and improve outcomes for participants, the Department has changed its service delivery process to promote collaboration between services providers. The Department has 24 navigators now hired around the state in seven regions. This service is designed to address participant needs and will assist participants in becoming as independent and self-sufficient as possible. Navigation staff will work with participants and their families to identify resources and natural supports to maximize their strengths and their capacity to manage their own lives. Of primary focus is the navigation of the programs, to assure that the Department has early intervention to urge the prevention activities to assist individuals from needing to penetrate further into the Department's system, and to utilize community and natural supports as much as appropriate and as possible for that individual. The Department has identified specific target populations and is working with regional staff and communities for referral into the navigation services. The target populations include: 1) individuals seeking a particular service that is beyond the scope of the program the individual is enrolling in or is currently enrolled in; 2) emergency assistance applicants; 3) food stamp households with children with no household income in the last 90 days; 4) TAFI relative care applicants; 5) TAFI households who have used more than twelve months of the time limited cash assistance; 6) child welfare not accepted for child protective services; and 7) children not accepted for children's mental health services. This is the basic fundamental of the navigational service; it's designed to provide short-term options of case management support to these client populations. Utilizing assessment tools, program staff will identify individuals and families who may benefit from working with Department navigation staff. Navigation services are strengths-based; navigators work with participants to identify their strengths and how those strengths can be used to achieve the participants' goals. Navigation staff will help participants identify prevention or early intervention activities or services as well as connecting participants to community services. Navigation services address participant needs and will assist participants in becoming as independent and self-sufficient as possible. Navigation staff will

work with the participants and family to identify resources and natural supports to maximize their strengths and capacity to manage their own lives.

Mr. Deibert also reviewed the navigation supervision organizational chart and stated that supervision of the navigation units will be the responsibility of the Central Office Support Team Program Manager, with direct supervision provided by Support Team Program Specialists.

Mr. Deibert reported that one of the strategies in a business model for service integration is to reach out to community service partners to assure that services are coordinated and available, and that effective communications are established between the navigation team and the services within the Department and community partners. The Department has found that this particular strategy has been extremely beneficial in providing opportunities to link individuals who are seeking more services, with natural supports and community supports that are much more meaningful and have a much greater long-term benefit to the individual client than just solely relying on individual services. Mr. Deibert commented that the Department's service integration strategy, has been recognized by the Western Interstate Commission for Higher Education, Keating Services Research Institute, as a promising and emerging best practice in the United States for the delivery of human services in rural communities. That designation provides the Department with access to research expertise from that commission.

Board members commented that one of the complaints heard from the Legislature related to services integration was, "My golly, the Department of Health and Welfare is going out and trying to find people, bringing them in and spending more money." Mr. Deibert responded that as the business model has been defined this past year, and the Department has been able to truly demonstrate that this isn't the average "go out and find clients." This is an effort to make sure that people who come to the Department receive the appropriate service.

It was noted by a Board member that what the Department is doing is similar to preventive medicine and it should keep up the good work.

### **Customer Service**

Tracy Farnsworth, Administrator, State Hospital South, stated he appreciated the invitation to provide a brief update on customer service. Mr. Farnsworth reported that recently, former Director Kurtz requested he evaluate the Department's customer service program. A team of about 15 people representing every division of the Department has been assembled and a simple charter outlined. The team is reviewing the current plan, trying to figure out if it needs to be tweaked, modified, or maybe blown up and reinvented. Above all, the team is trying to figure out how to breathe new life and energy into the customer service initiative so that it sticks, and that over time the Department really becomes more customer oriented. Some very unscientific, unofficial surveys of middle and senior management teams were recently conducted. One of the questions was: How would you rate the Department's customer service? On a scale of 1 – 10, the average was 7.0; this indicates the folks surveyed believe the Department can do better. There is a genuine sense of enthusiasm amongst the team to revive the customer service plan; however, there are some obvious challenges that need to be addressed in an effort to raise the bar. There are five issues or challenges: 1) The team recognizes that with any initiative, if there's not serious leadership and executive buy-in and sponsorship that the initiative will just die. The team is anxious and eager to have the new Director apprised of what the team is doing and get the Director's approval and support. 2) The team realizes that surveys are critical; there are various customer service surveys that occur here and there; however not consistently. It is a known fact that staff manages what is measured and therefore the Department needs to take a harder look at how it surveys what staff is doing in the area of customer service. 3) Communication and dialogue: as an organization, the Department has three values: integrity, quality, and customer service. The Department also has five established guidelines of

customer service, six principles of partnership that are critical to the service integration industry, and five disciplines of a learning organization. If employees are asked to name some of these values, principles, etc., some employees will say they know some, all, or none of the above. These are all very powerful and compelling organizational principles and practices. The team believes that there has to be some way to take the three of this, five of that and integrate them in some way that there's a little more synergy, more integration, and therefore more results coming out of all these various credos. The team is not quite sure how to do this, other than to say that it is an issue and the team is going to figure out how to bring more power to those various credos. 4) The team is struggling with whether or not to put this forth as a Departmental general principle on customer service, or whether to prescribe very precise expectations. There are some compelling upsides and downsides to both; do you teach people correct principles and expect them to govern themselves, or does the Department write the script and tell staff exactly what they ought to do and how to do it. The team is wrestling with the right balance and is anxious to seek the Director's input on how to proceed and move forward. 5) The phone system – trying to reach a live person both from the internal and external context. Many issues come in to play: various phone systems across the state, staff resources, and clients rolling over to voice mail or an automated attendant. This issue is not unique to the Department; however it is quite often trying, for both the client and staff to connect with a live body when something is needed. The issue of technology (updated phone system) is critical when you deal with customer service. Absent the right technology, how can any organization deliver effective customer service? Mr. Farnsworth concluded by stating the committee is energized and delighted with the opportunity to take a look at customer service; it is complex and the team wants to do this right. The team wants to ensure there is executive leadership and Board input, and buy-in so that the customer service initiative can sustain itself.

Board members commented that it sounded like more staff training would be needed related to customer service and if that were the case, so be it.

Board members also commented that one of the things that they have heard about Health and Welfare is the lack of communication or sharing of information from division to division. Is this a customer service issue or is it a departmental issue, and is it really a problem within Health and Welfare? Director Armstrong responded the Department serves numerous customers, both externally and internally. The better that communication flows internally within Health and Welfare and other Departments, the more accurate and complete will be the integration of information with the external customers as well. Leadership needs to ensure that the Department continually improves its communication processes and gets the information to middle, supervisory and frontline staff.

Mr. Butler stated that at this past legislative session, legislation passed which allows for a more seamless sharing of information between all of the components of the Department of Correction and the Department of Health and Welfare, particularly in the area of mental health issues. There was a significant problem identified in getting information from the County jail to the state prison, to the Department, to the Board of Correction, etc., so all interested parties joined together to develop the legislation and were successful in getting it passed.

**AGENDA ITEM #5:     NEW BOARD RESPONSIBILITIES**

Dave Butler, Deputy Director, reported that the Legislature passed House Bill 832 this past session, and the bill has far-reaching impacts as it redefines the roles and responsibilities of the Board. House Bill 832 was brought into focus as a result of a management report on Health and Welfare by the Office of Performance Evaluations. The report didn't say the Board was not performing its fiduciary responsibilities, but that there were other Boards that were more active, and recommended that this Board be more involved in the Department's operations. In essence, the primary changes are that the Board

expands from seven members, which are appointed by the Governor, to include four more members. The additional four members are the Chairpersons of the Senate and the House Germaine committees or their designees, the Director of Health and Welfare who will serve as Secretary, and a member designated by the Governor's Office. The Governor's Office representative and Department Director are non-voting members; however, but the Chairs or their designees are voting members. Representative Block has already stated that she will be on the Board; Senator Compton has not confirmed one way or another. Beyond the expansion of the Board members, was the change in roles and responsibilities. Mr. Butler called attention to page 11 of House Bill 832, Section 10, which outlines additional responsibilities for the Board that states, "in addition to any other powers or duties granted to the board under law the board shall: 1) advise the director and the governor on the fiscal policy and administrative matters; 2) review and advise the director regarding department strategic plan and performance measures; 3) develop roles and standards to measure department's efficiency and effectiveness; 4) and review and advise the director and the governor on department initiatives." Section 11 states, "the board shall provide an annual report to the governor and the legislature prior to the start of each legislative session addressing: 1) key department fiscal and policy issues; 2) the department's managerial and overall performance; and 3) the major proposed and ongoing departmental initiatives." Mr. Butler explained that it was because of this new directive that staff spent the majority of the morning presenting overviews on the Legislative Update, Medicare Part D, Service Integration, and Customer Service. The Department is a large organization with many moving parts and management does not want to cram all this information in one or two meetings. Mr. Butler further reported that he, Chairman Kenyon, Vice Chairman Roberge and Ms. Puett met approximately two months ago to begin discussions on the roles, responsibilities, time frames for development and review of the strategic plan, budget, annual report, the Department's various initiatives, and the impacts of the bill to Board members and Department staff. Chairman Kenyon and Vice Chairman Roberge commented that the work created by House Bill 832 was quite mind-boggling and questioned how many staff and how much funding had been allocated to support the additional work. Unfortunately, the Legislature did not allocate any staff resources and only \$22,000 was listed as the fiscal impact (no new appropriation was provided) for the additional Board member travel related to the additional meetings, per-diem and cost incurred for board mailings, prep work, etc.

Mr. Butler distributed and reviewed the Board oversight requirement schedule that staff developed. The schedule notes leadership meetings; the budgetary cycle; strategic plan, rules, legislative and Department initiatives calendar; and major projects calendar. Due to the massive amount of work the Board must now be involved in, Board meetings will now be held every other month: July, September, November, January, March, May, and will most likely be two-day meetings. Today's meeting was scheduled for a one-day meeting and staff has covered a lot of initiatives and only two rules dockets. Obviously the more dockets presented, the longer the meetings will be.

In regards to staff resources, Mr. Butler reported that currently, Ms. Puett supports the Board as one of her many responsibilities. Lauren Laskarris was recently hired as a management analyst in Management Services and will be assisting Ms. Puett in various Board related projects. One of Ms. Laskarris' responsibilities includes the development of the now required Board annual report.

Board members provided the following comments/observations:

- "My sense from the Legislative process was that there is a very clear message that the Legislature wants the Board to be much more actively involved in the advising of the Department's processes, and to look at its efficiencies and effectiveness; not to necessarily have more authority on how it carries its operations. The question is how deep does the Board go?"
- "I had the impression when I was talking to Legislators that they want this Board to be an independent Board, not part of the Department of Health and Welfare - - more outside looking in

to see what's going on. So to the extent that the Board can do that, I think it will meet Legislature's needs."

- "With regards to policy, I really don't want to be in a position of looking at every Director's rule. We could do that; however, I don't think that was the intent of the Legislature and I think it could divert us from some of the other things that I see here. The scope of the Department is so huge, if we look at the whole thing it's almost overwhelming, but identifying maybe some key initiatives, and the two or three key fiscal issues, or a few key policy issues would be manageable. Some possibilities to track would be to look at substance abuse system recommendations, and the Department managerial and overall performance related to the issues of staff dissatisfaction referenced in the OPE report. How about if the Board tracks what's going on around changes in those areas. The Board needs to try to come up with a manageable level of stuff that it can do, not just get totally overwhelmed with all of the Department's operations, but enough to reasonably manage. It obviously would be important to track Medicaid modernization, but on that one I see us getting reports on what's going on, or have the opportunity at meetings to ask questions in any particular area. I see the Board at the front-end of the strategic planning process--review where the Department is starting in planning and where it plans to go, and be able to do some advising closer to the front-end. Also, other things like service integration, etc., get routine reports or look at benchmarks; however, I don't see the Board telling the Department how to do service integration."
- "Another area of concern to me is performance evaluation. I'm not sure that I'm in a position to evaluate whether the Department's doing a good job or not. Overall, I'm not an MBA or anything like that. I think it was suggested that we hire a consultant; however, this was rejected by the Legislature's infinite wisdom, so how are we going to do that?"
- "I think it's probably going to be fiscally and physically impossible for those Board members who do not live in the immediate area to be involved to any great degree. They just can't drive and/or fly to Boise in a moments notice."

Mr. Butler reported that the Board's observations were similar to the discussion held two months ago. Also, in looking at the annual report, the Board doesn't want to create an annual report that is just a reiteration of Facts, Figures and Trends, which the Department develops and provides to everyone. The annual report actually needs to be developed from the perspective of the Board. The Board should be able to state, "We are working with the Department and have reviewed the strategic plan, budget, legislative audits, OPE audits, received information and updates on the major computer systems that are being replaced, and are satisfied with the operations of the Department. We've talked about the commissions, whether that's the Substance Abuse and Mental Health Commission or whether that's the Idaho Health Quality Planning Commission, and have had the opportunity for discussion and input." The annual report will be developed from the Board's perspective and technical writing assistance provided by Communications staff and Ms. Laskarris.

Mr. Butler stated that the Department does have a contract with Fox Consulting, which is a governmental health and human services expert. The Department has a standard rate with the consulting firm, and if the Board chose to have something evaluated, the firm could be obtained under the Departmental contract and rate. As previously mentioned, funds were not appropriated for this type of work, so potentially internal Departmental funds could be used as long as funds are available.

Mr. Butler questioned if it was the Board's preference to continue to meet in Boise as it has previously done—at a standard time and location. With the Board's new directive to be involved in the Department's initiatives, i.e., service integration in Region 2, would the Board want to meet in Lewiston and/or the respective Region/initiative? Also, does the Board want to consider meeting in Coeur d'Alene and be part of the Employee Recognition event scheduled in September? Mr. Butler reiterated that

limited funding was allocated for travel, so travel would be on a limited basis. Travel would be dependent on the agenda; if there are a lot of rule dockets, obviously, the meeting will be held in Boise. However, if it was more of an update meeting covering budget, legislative audits, or some of the key initiatives, the meeting could potentially be held at the Regional office so Board members could see first-hand what was going on in the Regions.

Board members commented that they are interested in what is happening at the various Regions and would like to meet in those areas; however, the agenda will dictate the meeting location. The Board is in agreement with Department staff that when the agenda is full of rule dockets, the meetings will be held in Boise. If there is a good reason to meet at a Regional Office and review key initiatives, then the Board and Leadership will evaluate and decide on location well in advance of the meeting.

Chairman Kenyon made the following recommendation. Since there will be nine members on the Board, consider assigning each of the members, to a sub-committee consisting of two to three members. The subcommittee would have something to look into and then report back to the full board. With this approach Board members wouldn't be overwhelmed with learning and reporting on all programs.

Board members agreed this would be a manageable way to proceed; Chairman Kenyon will work with Mr. Butler to work out the details.

**AGENDA ITEM #6:      DEVELOPMENTAL DISABILITIES AGENCIES**  
**DOCKET NO. 16-0411-0601 (TEMPORARY)**

Ken Deibert, Division Administrator, Family and Community Services, reported providers of developmental disabilities agency (DDA) services have identified a gap in services available to people with developmental disabilities. Most direct services available in a DDA are delivered by paraprofessionals or Master's level professionals. Providers have suggested that there should be an optimal service that could be delivered by bachelor's level social workers and would meet the objectives of the service of "supportive counseling" as identified in IDAPA 24.14.01. The proposed rule changes define the service of supportive counseling and state the related requirement for delivery of the service including assessment, documentation on the plan of service, and the staff qualifications.

Discussion ensued and questions entertained regarding supervision and the reimbursement requirement. Mr. Deibert responded that the previous rules allowed Bachelor's level Social Worker to bill supportive therapy services under Medicaid under psychotherapy code. When the Board of Social Work examiners excluded BSW social worker from performing psychotherapy, this eliminated the DDA's ability to bill for supportive therapies provided by BSW staff. The new rules define what constitutes supportive therapy and who can perform this service. There is a companion rule from Medicaid that will be coming to the Board that identifies what the reimbursement rate is. This rate will be lower than rate previously billed by the DDA's for psychotherapy. The fiscal impact to Medicaid is within the expenditure range that previously had been experienced by the Department for the psychotherapy services being provided by the DDA's. This is not an expansion of services, it is really a clarification and more precise definition of what can be billed by Bachelor's level of Social Workers. Billing has to occur within the context of limits for the overall hours of psychotherapy. All services will continue to require prior authorizations.

**Motion:**                      Dr. Roberge moved that the Idaho Board of Health and Welfare adopt as temporary, Rules Governing Developmental Disabilities Agencies as presented under Docket No. 16-0411-0601, with the effective date of the temporary July 2006.

**Second:** Don Gross

**Vote:** Motion carried. 5 Ayes 0 Nays 2 Absent

Lisa Cahill, Idaho Association of Developmental Disabilities Agencies, testified in support of Docket No. 16-0411-0601. Ms. Cahill stated she was glad that the motion was approved; that the Association supports the motion, and supports the work that Mr. Deibert did with the Association members related to supportive counseling. The Association would like to have consideration given to have social workers and a physician sign off on supportive counseling. The Association is appreciative of the fact that consideration is being given to a change in fee reimbursement.

Carl Jones, Idaho Association of Developmental Disabilities Agencies, testified in support of Docket No. 16-0411-0601. Mr. Jones stated that as a private provider, he appreciated the opportunity to work hand in hand with the Department and other key stakeholders involved to work something out and keep costs under control. Everyone has a vested interest in sustaining this process, and thanked Mr. Deibert for his assistance.

**AGENDA ITEM #7: RESIDENTIAL CARE OR ASSISTED LIVING FACILITIES IN IDAHO  
DOCKET NO. 16-0322-0601 (TEMPORARY)**

Randy May, Deputy Administrator, Medicaid, reported that in January 2006, during the legislative review process for the re-written rule governing Residential Care or Assisted Living Facilities in Idaho, Docket No. 16-0322-0502, the Department committed to promulgating a temporary rule, at the first window of opportunity, to add a grandfather clause to the section of rule requiring fire-suppression sprinklers for certain facilities that accept residents who are incapable of self-evacuation. What this rule proposes to do is extend the grandfather clause requiring fire suppression sprinklers in certain facilities where there are some residents that are incapable of self-evacuation. This will allow these facilities covered under the grandfather clause to have additional time, approximately four years, to become compliant with the sprinkler requirements. The intent of the rule is that, effective July 1<sup>st</sup>, 2010, those 26 facilities that had been previously grandfathered will either have to have sprinkler systems installed or they will have to discharge residents incapable of self-evacuation. The proposed rules also cleans up some language around written interpretations, clarifies conditions where the admission rate can be terminated and deletes the phrase, "or administrator" from the section dealing with enforcement because that is now covered under the purview of the Bureau of Occupational Licensing.

Lengthy discussion ensued and the following comments provided by the Board.:

- Board members stated they were really having a problem with the 26 facilities given a window of four years to install sprinkler systems. They likened this to the Board sitting on their hands for four years and hoping that nobody died, got injured, or who knows what else because of the direction of the Legislature. The saving of a potential life or lives is at stake.
- Consider adding language to the rule, which would restrict facilities that do not have sprinkler systems installed, from accepting patients incapable of self- evacuation.

Board members raised the following questions: 1) How many of these facilities are there in Idaho and how many have sprinkler systems? 2) What if the Board does not approve these rules unless the date of the grandfather clause is moved up by two years or is made effective this year; could this not be done by changing the language in the rule? And if the language is changed, could the Legislature reject the rule at the upcoming session? 3) Does the Department know how many patients are incapable of self-evacuation in the 26 facilities? 4) Has the Department contacted the facilities to give them financing or low interest rate information? It was noted by Board members that many of these facilities are "Mom &

Pop” type operations and don’t necessarily have the financial means to install a sprinkler system without financial assistance. The Board stated its primary concern and responsibility was the health and safety of vulnerable patients in these facilities, and the potential to save lives.

Mr. May responded that there are currently 271 facilities licensed in the state to provide residential or assisted living. Of those facilities, 26 of them do not have fire suppression sprinkler systems and under the old grandfather rules could take in residents who cannot self-evacuate. Those same 26 facilities can also take residents in who are capable of self-evacuation and not install a sprinkler system. It is a facility admission and retention issue. With all of the other facilities that do not have a sprinkler system—around 43 statewide--when they apply for their license, they have to declare “We are going to take only residents who are capable of self-evacuation,” then they do not require a sprinkler system. Conversely, when they apply for their license they can say, “We will take residents who cannot self-evacuate,” in which case they have to install a sprinkler system.

Mr. May commented that he has no way of knowing what the Legislature will or will not do should the Board reject or change the date of when the sprinkler systems must be installed. Mr. May stated he did not have a break down of how many residents in those 26 grandfathered unsprinklered facilities are not capable of self-evacuation; he estimated about 50% of the population in those 26 facilities, or about 126 residents, are incapable of self evacuation. Mr. May will follow-up with that information and obtain an accurate count. As far as financing, Mr. May stated that there are some potential avenues for assistance, similar to the revolving loan fund that Water Resources has used in the past.

Lengthy discussions again ensued with Board members stating they could not and would not accept the rules as written and potentially place any vulnerable adults at risk. Board members stated they would feel comfortable in approving the rules only if the effective date of requiring the 26 facilities to have a fire suppression sprinkler system installed was changed from July 1, 2010, to July 1, 2007. Moving the date to July 2007 also give the Legislature an opportunity to review the Board’s decision at the upcoming legislative session.

**Motion:** Stephen Weeg moved that the Idaho Board of Health and Welfare amend the Rules Governing Residential Care or Assisted Living Facilities in Idaho, Docket No. 16-0322-0601, and Section 150.05.h be amended and the date of July 1, 2010 be changed to July 1, 2007. This motion encompasses all references to the July 1, 2010 date within this docket.

**Second:** Dr. Roberge

**Vote:** Motion carried. 5 Ayes                      0 Nays                      2 Absent

**Motion:** Stephen Weeg moved that the Idaho Board of Health and Welfare adopt the Rules Governing Residential Care or Assisted Living Facilities in Idaho, as amended by the Board, and as presented under Docket No. 16-0322-0601 with the effective date of the temporary July 1, 2006.

**Second:** Dan Fuchs

**Vote:** Motion carried. 5 Ayes                      0 Nays                      2 Absent

At 10:00 am, Chairman Kenyon called for an Executive Session of the Board so the Department could discuss personnel matters.

**Motion:** Dr. Roberge moved that the Idaho Department of Health and Welfare move into Executive Session according to the Open Meeting law, Section 67-2345(1)(a), Idaho Code, relative to discussion of personnel matters.

**Second:** Dan Fuchs

**Vote:** Motion carried. 5 Ayes                      0 Nays                      2 Absent

The Board was advised of potential appointments of staff by the Director. No action was taken by the Board.

Chairman Kenyon reconvened the regular business session of the Board at 10:30 am.

**AGENDA ITEM #8:      MEDICAID REFORM**

Patti Campbell, Project Manager, Division of Medicaid, gave a presentation on Idaho's Medicaid reform, the project timeline, the benchmark benefit plans under Medicaid modernization, the enrollment process, the reform rules framework, and the Department's communication to its participants and partners.

Ms. Campbell presented brief background information and reported that in mid 2005, Idaho Medicaid began to design a modernization plan to increase program quality and achieve fiscal sustainability. The plan was to create Medicaid eligibility categories and benefit plans based on identified health needs. The plan also included program administration reforms, with Medicaid staff proposing to use federal Section 1115 Waiver authority for reform.

A concept paper was presented to the Centers for Medicare and Medicaid Services in July of 2005 and in February of 2006, the Idaho Medicaid Simplification Act was introduced in Legislature along with a package of companion bills. Governor Kempthorne signed the Simplification Act into law on March 31, 2006, and Idaho submitted its Section #1115 Waiver request on April 24, 2006.

Concurrent to the Medicaid reform planning efforts in Idaho, Congress created and passed the Deficit Reduction Act (DRA) of 2005; this was signed by the President in February of 2005. In March of 2006, Michael Leavitt, U.S. Secretary for the Department of Health and Human Services, issued guidance to states on the DRA impacts to Medicaid. Subsequently, in late April of 2006, the Centers for Medicare and Medicaid Services recommended that Idaho use the DRA provisions to authorize program reforms instead of a Section 1115 waiver.

Ms. Campbell explained that Section 6044 of the DRA allows the use of benchmark benefit plans that may consist of different benefits than "standard" Medicaid. The provision allows Idaho Medicaid to create tailored benefit plans for low-income children and working-age adults; for individuals with disabilities or special needs; and for elders or those otherwise dually eligible for Medicaid and Medicare. These benchmark benefit plans will align Medicaid services with the health needs of participants and also serve as three separate eligibility plans for different Medicaid groups. Idaho secured federal authority for these benchmark benefit plans in May 2006 through the DRA and amendments to Idaho's State Plan for Medical Assistance. Idaho also secured approval of several additional State Plan amendments that authorize changes to Medicaid management, such as consolidated purchasing.

Some of the outstanding issues are that certain other DRA provisions affecting Medicaid reforms are complex and require additional interpretation, including provisions on use of co-pays. And in addition,

DRA impacts on Idaho's premium assistance, health information technology, and caregiver support initiatives require additional interpretation before planned reforms can take place.

Ms. Campbell briefly reviewed the three benchmark benefit plans: 1) The Medicaid Basic Plan – this is for low income children and adults with eligible dependent children. This plan provides complete health, prevention and wellness services for children and adults who do not have disabilities or other special health needs. 2) The Medicaid Enhanced Plan – this includes all services of the Medicaid Basic Plan Benefits, plus additional services to meet the needs of participants with disabilities or special health concerns. The services in this plan include the full range of services covered by the Idaho Medicaid program. 3) The Medicare – Medicaid Coordinated Plan is under development. This plan is for individuals who are also covered under Medicare.

Ms. Campbell explained that beginning in July 2006, new Medicaid participants will be enrolled in either the Medicaid Basic Plan or the Medicaid Enhanced Plan. Existing Medicaid and CHIP-A participants will be transitioned to one of the new plans as part of annual eligibility renewal. Children currently covered under the CHIP-B program will be transitioned to one of the new benefit plans effective July 1, 2006. Plan assignment is based on individual health needs.

Ms. Campbell noted that extensive work has been done by Department staff, Governor's office and many Legislators to get Medicaid Reform through all the approval process at the state and federal levels. A significant coordination of efforts has been expended in communication with participants, providers, other state agencies, medical associations, and in disseminating information on Idaho's Medicaid Reform. Some of those efforts include: newsletter articles, group presentations, direct mailings, Q & A on website postings, and Medicaid information releases.

Representative Block commented that it had been a great experience and a pleasure to work with the Department of Health and Welfare and the Governor's Office on the reform package. Representative Block noted that the House Health and Welfare Committee had been concerned about budget increases as well, and had been working for two years to get ideas together and possibilities of legislation. When the Department contacted the Committee, the Committee noted that many of their respective ideas overlapped. Representative Block commended the Department for working so well with the Committee and accepting the Committee's ideas, as well as integrating the Department's idea to make this work; Medicaid Reform was a great accomplishment!

**AGENDA ITEM #9:     END OF YEAR UPDATE**

Mr. Butler reported, that time permitting, a few year-end updates will be given.

Mr. Deibert reported that about two years ago, the U.S. Department of Health and Human Services, Administration for Children and Family Services (CFS) conducted review of Idaho's child welfare program. CFS identified areas in which Idaho was meeting the national standards and identified other areas where Idaho was not meeting national standards. Following the review, the Department and CFS engaged in a process of establishing a program improvement plan, developing goals and objectives for overall improvement in the child welfare system. Idaho completed its review in March 2006 and has fully completed all of the objectives and met all of the performance standards for the program. Idaho is only one of two states during this review period that has completed its performance improvement plan and will not be subjected to continued oversight by CFS. Idaho's next review is scheduled in the next eighteen months; a confirmed date has not been received. This is a major accomplishment for the Department in terms of overall development in its child welfare program. It indicates that the Department is working towards meeting the national standards, and that it was able to achieve fairly substantial improvements in developing program services.

Board members commented that the Department has received some flak over the years due to the error rate in the welfare eligibility program. Board members have found this ironic as Legislature cut out funding for the eligibility examiners and then complained because the error rate went up. Where does the error rate stand?

Mr. Butler responded that the Department has decreased the error rate each of the last two years even though the Department continues to receive a federal sanction. Year-to-date, the Department's error rate is right around 5.63%; the Department has been advised by the Food and Nutrition Services that if it can reduce the error rate below 6%, Idaho would no longer be in sanction. The error rate has been reduced from 9%, to 8% and is now right around 6%. Kudos go to Russ Barron and Self Reliance staff who have worked hard over the past year; they are making tremendous strides and great headway on reducing the error rate.

Mr. Butler reported that a majority of the Department's fund savings is in the area of Medicaid trustee and benefits as expenditures were down in this area; there is approximately an \$18 - \$20 million dollar savings. Also, as previously mentioned, all staff will receive a \$700 bonus in July. Legislative intent was that personnel dollars stayed in the personnel fund, so as the fiscal year end approached, leadership noted there were personnel funds that would remain unspent. The decision was made by the leadership team to give everyone a \$700 bonus, so that money went out. Also, the targeted change in employee compensation that the Legislature gave several agencies for specific job classes, i.e., nurses, social workers, clinicians and the self-reliance specialists, have helped in the area of employee retention.

Finally, Mr. Butler reported the Division of Behavioral Health has been created. State Hospital North, State Hospital South, and adult and children's mental health and substance abuse services, which had previously been under the Division of Family and Community Services, are all being transferred to the new Division.

Board members requested information on the mental health substance abuse study, and on the Health Planning Commission.

Mr. Butler responded that there is a break-out commission appointed by House Concurrent Resolution 63, which will study the Department's delivery system on mental health and substance abuse services. The commission is chaired by Senator Joe Stegner and Representative Kathy Skippen and is reviewing and evaluating how the Department has delivered these services in the past, how services are currently delivered, or should these services be broken out of Health and Welfare and a new agency created to provide oversight. The Department obviously feels that it can handle delivery of these services. Governor Risch created the Division of Behavioral Health, which places more focus on those services. Thus, State Hospital South, State Hospital North, and all mental health and substance abuse services have been placed under this new division.

The second item is the Health Quality Planning Commission created by House Bill 738. This calls for stakeholders in Idaho's health system to come together to discuss three major health planning needs in the state: 1) coordinated implementation of health information technology; 2) coordinated implementation of patient safety standards and reporting; and 3) coordinated implementation of pricing transparency in health services and health insurance. Mr. Butler commented that letters inviting participation will be forwarded by the Governor's Office in the very near future.

Mr. Butler reported that there is a third study – this is actually an interagency committee on substance abuse prevention and treatment. The committee is directed to focus on statewide efforts to address

substance abuse based on a recommendation from the Office of Performance Evaluations. More information on this committee will be presented at the July meeting.

**AGENDA ITEM #10: MEET WITH DISTRICT HEALTH BOARD**

Board members met with the District Health Board to explore future collaboration and networking opportunities.

**AGENDA ITEM #11: REMAINDER OF BOARD MEETINGS FOR 2006**

Mr. Butler reported the Board will meet as follows: July 20 & 21, 2006 in Boise; September 21 & 22, 2006 – location to be determined by Mr. Butler and Chairman; and November 16 & 17, 2006 in Boise.

**AGENDA ITEM #12: ADJOURNMENT:**

**Motion:** Chairman Kenyon moved to adjourn the meeting at 3:40 pm.

**Vote:** Motion carried. 6 Ayes                      0 Nays                      1 Absent

**Respectfully signed and submitted by:**

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Quane Kenyon, Chairman, Health and Welfare Board

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Janet F. Penfold, Secretary, Health and Welfare Board

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Martha Puett, Executive Assistant and Recorder